ETATEMENT OF DEFIGIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILDI	TIPLE CONSTRUCTION	COMPLETED
	185012	5. WNG		03/16/2011
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLA GARE AND REHA	BILITATION CENTER	8	TREET ADDRESS, CITY, STATE, ZIP C 1600 PRIDE AVENUE MADISONVILLE, KY 42431	MPR AND
PREFIX . (SACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX T'AG	PROVIDER'S FLAN OF (EACH CORRECTIVE AC' GROSS-REFERENCED TO' DEFICIENT	TION SHOULD BE A TO THE APPROPRIATE DATE
#15521) were conducted 03/16/11 to determine the with Federal requirement compliance with Federal deficiencies cited at the KY #15521 was substant cited. F 157 483.10(b)(11) NOTIFY (INJURY/DECLINE/ROCALLIN	ne facility's compliance hts. The facility was not in I requirements with highest S/S of an "E". hilated with deficiencies OF CHANGES OM, ETC) ely inform the resident; is physician; and if hit's legal representative ember when there is an eident which results in ial for requiring physician change in the resident's hosocial status (i.e., a ental, or psychosocial ening conditions or need to alter treatment to discontinue an t due to adverse mence a new form of to transfer or discharge ity as specified in mptly notify the resident hit's legal representative her when there is a	F 157	"This Plan of Correcti and submitted as requisubmitting this Plan of Hillside Villa Care & Center does not admit deficiency listed on the nor does the Center ad	ired by law. By f Correction, Rehabilitation that the is form exist, mit to any acts, or the basis for the e Center allenge in legal ministrative ency, conclusions that deficiency." ent # 12 was 1/8/11 by the rector of ucation to LPN age of condition tification and ursing was re- evelopment

Ty deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 eye following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DRM CMS-2567(02-99) Pravious Varsions Obsoleta

Event ID: 8,7W11

Facility D: 100189

Fax:2708240199

it continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X3) DATE S COMPLE		
, ", <u> </u>	185012	a. WNG	and the control of th	03/	1 <u>6/20</u> 11
NAME OF PROVIDER OF SUPPLIER HILLSIDE VILLA CARE AND REHA	BILITATION CENTER	1	IEET ADDRESS, CITY, STATE, ZIP GODI 500 PRIDE AVENUE IADISONVILLE, KY 42431	E	
GREEK (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED YO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XL) COMPLETION DATE
the address and phone legal representative or This REQUIREMENT by: Based on record review determined the facility f physician was notified in requiring physician inter (#12), in the selected se include: Resident #12 was admit 09/01/07 with diagnoses injury of C5-C7, Lack of Weakness, History of Uniabetes Melitis, Renal Morbid Obesity.	and periodically update number of the resident's interested family member. Is not met as evidenced and interviews, it was alled to ensure the mediately after an injury vention for one resident ample of 15. Findings Ited to the facility on to include Spinal Cord Coordination, Muscle inary Tract Infections, Failure, Paraplegia and and the facility on the facility of the facility	F 157	heating beverages and the of residents to include reliquids to the resident's pensure their safety and meeded adjustments to the 3/18/2011. Current residents with evereviewed on 03/31/11 by of Nursing Services to emphysician, resident and reparty/family notification completed. No residents identified. To ensure that the physiciand responsible party/famination of condition the licensed nurwere re-educated by Staff Development Coordinator of condition to include physician notification on 3/18/11. To ensure that no other rebe affected the Director of Nurs Staff Development Coordinator conduct weekly audits for the monthly audits for two physician notification of condition. Identified issued	cheating of calatability to cake any e beverage on ents were the Director asure esponsible was were esponsible was were esponsible change in ring staff for on change cysician esidents will four weeks, we months on changes in changes in	

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY GOMPLETED
	, 4.0.10	185012	A. BUILDII		03/16/2011
	ROVIDER OR SUPPLIER	ABILITATION CENTER		REET ADDRESS, CITY, STATE, 219 CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431	
(X4) ID PREFIX YAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
	off in my hand". An observation of a second 03/16/11, revealed (approximately 2.5 cm. Resident #12's lower. An interview with Lice #1, on 03/16/11 at 3:5 approximately 8:30 Pt summoned her to the her that he/she spilled abdomen. She deane saline and a gauze paresident and monitored morning. LPN #1 notified in not notify the resident resident call the Direct formation of the physician one tied my hands, I would be a second information on the password information on the password information puter. She passed Resident #12 to the number morning at 7:00 All interview with Reside 3/16/11 at 5:49 PM, revenue also did not recall it esident after the burn over related to the burn over related to the burn over the second in the password information at the put of the password information at 7:00 All interview with Reside 3/16/11 at 5:49 PM, review also did not recall it esident after the burn over related to the burn over the password in the put of the password in the put of the put of the password in the put of the	kin assessment, conducted an irregular shaped by 1.5 cm) red lesion on abdomen. Insed Practical Nurse (LPN) O PM, on 01/07/11 at M, revealed Resident #12 resident's room and told coffee on his/her of the burn with normal of to get "sticky stuff" off the off the on-coming shift but ent's physician. She stated, ector of Nursing, I was and get things done. If because I just didn't. No as new and I just didn't she did not complete an eight was new to the eight was new to the the correct identification on to access the the information regarding se who came on duty the M. Lent #12's physician, on vealed she did not recall off Resident #12's burn. If she had examined the resident #12's burn.	F 157	corrected upon discovery. The Director of Nursing will report results of these audits monthly Performance Improvement Committee, which includes the Medical Director, Administrate Director of Nursing, Health Information Manager and Maintenance Director, for furth recommendations. Completion date	to the or,

ORM CMS-2567(02-99) Previous Versions Obsolate

Event (D: 8J7W11

Pacility (D: 100189

If continuation sheet Page 3 of 12

CENTERS FOR ME	DICARE &	MEDICAID SERVICES				OMP	NO. 0936-038
STATEMENT OF DEFICIENT AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ULTIPLE	CONSTRUCTION	(X3) DATE CÓMPI	
		186012	B. Wil	iG		03	1/16/2011
NAME OF PROVIDER OR S		A DOLLAR APPEAR		1	T ADDRESS, CITY, STATE, ZIP CCO PRIDE AVENUE	E	
HILLSIDE VILLA CAR	E AND REH	ABILITATION CENTER		MAI	DISONVILLE, KY 42431		
(X4) ID (EAC FREFIX REG TAG REG	H DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
the twenty been torn to located. S #12 had no	it 5:58 PM, four hour in from the log the stated to the stated to	revealed all three copies of nursing logs for 01/08/11 had g book and could not be he incident with Resident orted to the facility and no		157	·		
An intervier PM, reveal coffee to be PM. CNA a coffee in the and did not before givin back into the light thirty in looked like abdomen, had spilled stomach. Cand was told care of Resi bandage was questioned instructed Candwedge,	w with CNA ed Resider e reheated f1 stated s e microwal check the g it to the resident innutes late a red whelp The reside the reheate NA #1 info dent #12's is over the ner about t NA #1 or o about any	A #1, on 03/16/11 at 7:10 at #12 requested his/her on 01/07/11 around 8:00 he reheated the resident's re for one to two minutes temperature of the coffee resident. The CNA went is room to answer the call or and observed what on the resident's hat stated to her that he/she and coffee on his/her rimed the Charge Nurse Charge Nurse would take wound. The next day a area and no one the incident. No one ther staff, to her precautions for attures since the incident.					
PM, revealed reported Rest his/her abdo cleaned the a gauze on the clothing and observed the called the ph	d on 01/08. Ident #12 men the pr wound with he area to bed linens wound an ysician to	#2, on 03/16/11 at 8:00 #11 at shift change, LPN #1 had spilled coffee on evious evening. She had in normal saline and placed prevent friction with LPN #2 stated she d it looked "red". LPN #2 hotify her of Resident ain treatment information.					

FORM CMS-2567(02-99) Previous Versions Obsolelle

Eveni ID: 8J7W11

Facility ID: 100183

If continuation sheet Page 4 of 12

The physician prescribed Silvadene cream to be

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				7	<u> 10.0938-0391</u>
STATEMEN	OF DEPICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA	(X2) t	NULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	עפ א	ILDIN	G		
		185012	8. WI	NG		03,	/16/2011
	ROVIDER OR SUPPLIER	ABILITATION CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 600 PRIDE AVENUE MADISONVILLE, KY 42431		
] 10	PROVIDER'S PLAN OF CORRECT	CION	, (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE FRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	GOMPLETION DATE
F 253 SS=C	Continued From page applied to the wound she completed the two log and placed the pirthe Director of Nursing 483.15(h)(2) HOUSER MAINTENANCE SER The facility must provious maintenance services sanitary, orderly, and of the facility must provious determined the facility maintenance services comfortable interior. Coresidents' rooms reveauser in disrepair and the personally owned wind because their rooms with facility failed to provious facility failed to provious the facilit	twice daily. LPN #2 stated enty-four hour nurse's report all copy in the drop box of acceptance of the copy in the drop box of acceptance of the copy in the drop box of acceptance of the copy in the drop box of acceptance of the copy in the drop box of acceptance of the copy in the	F	157	F253 Resident #16, #17, and #18 w refunded for the cost of the air conditioners by 4/5/11. The Maintenance Director comple audit on 3/16/11 of baseboard An agreement was completed 4/8/11 with Jones and Sons M and Welding to complete the identified baseboard heaters re5/9/11. Maintenance Director complet temperature checks on 3/15/11 hallways, dining room, and rar resident rooms with no abnormanges or resident/family concuncomfortable temperatures. I rooms were checked for air	ted an heaters, on achine pairs by ed in ndom nal erns of	
	time revealed the facilit heating system that dat Resident rooms had ba	aintenanca Director at the y had the original boiler ed back to the 1980s. seboard (radiator type) oms but the temperature					

CENTERS FOR MEDICARE	MEDICAID SERVICES	Tuen N	ch market	LE CONSTRUCTION	(X3) DATE 8L	IRVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII			COMPLE	THO ·
$\mathbf{v}_{i} = \mathbf{v}_{i} + \mathbf{v}_{i}$	185012	3. WN	G		03/1	16/2011
NAME OF PROVIDER OR SUPPLIER			15	EET ADDRESS, CITY, STATE, ZIP CODE 300 PRIDE AVENUE ADISONVILLE, KY 42431		
(X4) ID SUMMARY S	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	08€	(XE) GOMPLETION DATE
leveis could not be a Residents who had frequently had them their rooms were too resident rooms were climate control syste areas and not efficie. The Maintenance Di rooms had a window air conditioner did no rooms comfortable in residents had purchased some air summer season. Residents had purchased some air summer season. Resident a window a conditioning units with but could not recall to placed. An interview with Reson 04/16/11 at approwhen the weather www.s. "Hot as Hait!". asked the facility offit who) for a window a Resident #16 comfortesident rooms. Here conditioner for Resident comfortable resident comfortable.	piler room and temperature adjusted for individual rooms. Window air conditioner units on in cold weather because that. In warm weather some to loo hot because the facility's aim was located in the hall and to cool resident rooms. The facility seem was located in the hall and conditioner and the hall of always keep resident warm weather and some ased personal window air. Administrator, on 03/15/11 5 PM, revealed she had conditioning units during the eview of purchase receipts air conditioner was purchased awas purchased on 06/28/10, ated one of the air as placed in the activity room where the other one had been seed warm Resident #16's room The family member had ce staff (couldn't remember in conditioner to keep thable. He/She was told that by window air conditioners for She purchased a window air dent 16's room to keep the	F.	253	conditioner units owned by other residents and/or families on 3/1 by the Maintenance Director and Business Office Manager. Non identified. The Maintenance Director was educated by the Administrator of 3/16/2011 to report any uncommon temperatures or the need air conditioner so that it may be replaced. To ensure comfortable temperature Maintenance Director or Housekeeping supervisor will complete temperature checks, to include resident rooms twice a for two weeks and once a week one month and as appropriate weather conditions and season changes. Identified issues will addressed at that time. The Ma Director will report the results and audits monthly for 3 months to Performance Improvement Committee, which includes the Medical Director, Administrate Director of Nursing, Health Information Manager and Main Director for further recommend	6/2011 de were re- on fortable for an tures week for with be intance of the the	4/18/11

FORM CMS-2567(02-59) Previous Versions Obsalele

Event ID: 8.77W11

Facility ID: 100189

If continuation sheet Page 6 of 12

		MEDICAID SERVICES	1025	LLLTIP	LE CONSTRUCTION . (X3) DATE SU	
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	.S '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI			COMPLET	- ED
		186012	s. wh	Vancour - 100 -		03/1	6/2011
NAME OF PROVIDER OR SUF		NAME OF STATE		16	EET ADDRESS, CITY, STATE, ZIP CODE 500 PRIDE AVENUE		
HILLSIDE VILLA CARE				M	ADISONVILLE, KY 42431	d	(X5)
/FACH	DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
had resided during the pawas hot. Refan in an attercomfortable any good; the requested the cool the roor buy one. The reason he/shoto asked the cool plus one asked the cool the roor buy one asked the cool the roor buy one. The reason he/shoto plus one asked the residual transfer to the residual transfer transfer to the residual transfer transfer to the residual transfer trans	Resident in a different # in a different	#17 revealed the resident rent room at the facility her season and that room it is season and that room it is season and that room it is season and that room at a cure but stated, "It didn't do vas still hot". The resident provide an air conditioner to so told the facility could not not revealed that was the tione. Ident #18, on 04/16/11 at sher room was "Hot and on purchase an air	F	253			
conditioner." facility would comfort. F 323 483,25(h) FR HAZARDS/S The facility if environment as is possible adequate supprevent accident. This REQUIF by: Based on recident accident	Resider not provide the providents. REMENT cord revision dents.	at #18 stated he/she felt the ide an air conditioner for ACCIDENT	F3	23	F323 Resident # 12 was assessed by the licensed nurse at the time of the on 1/7/11 and evaluated. The physician was notified of the eventhe licensed nurse on 1/8/11. Che was re re-educated by the Staff Development Coordinator on the procedure for heating beverages the supervision of residents to in re-heating of liquids to the reside palatability to ensure their safety make any needed adjustments to beverage on 3/18/2011.	ent by NA # 1 and clude ent's and	

DRM CMS-2557(02-SB) Previous Versions Obsolets

Event 10; 617W11

FEOTIN 10. 100189

If continuation shadt Page 7 of 12

PRINTED: 03/30/2011 FORM APPROVED OME NO. 0836-0391

OFFAR	C SOR MEDICARE	& MEDICAID SERVICES				D. 0000 0001
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUILI		COMPLE	FEO
		186012	g, WING		03/	6/2011
	OVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, SYATE, ZIP CODE 1500 PRIDE AVENUS MADISONVILLE, KY 42431	<u>:</u>	
(X4) ID PREFIX TAG	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	n should be E appropriate	(X5) COMPLETION DATE
F 323	og/01/2007 with di Injury of C5-C7, La Weakness, History Diabetes Melitis, F Morbid Obesity. A review of a nursi at 4:30 AM, reveal coffee on his/her a nurse to call anyor additionally stated, nurse". An interview with F 3:25 PM, revealed 8:30 PM, the reside be reheated by Ce The resident stated and brought it back resident spilled it or resident did not rea spilled until he/she his/her shirt was w raised my shirt and and the skin dame An observation of a on 03/16/11, reveal (approximately 2.5 Resident #12's low An interview with C PM, revealed Resi coffee be reheated 8:30 PM. The CN resident's coffee in	admitted to the facility on agnoses to include Spinal Cord sick of Coordination, Muscle of Urinary Tract Infections, Renal Fallure, Paraplegia, and and Resident #12 spilled hot bedomen and did not want the let. The nurse's note "Will monitor and pass to 7-3 resident #12, on 03/16/11 at on 01/07/11 at approximately ent requested e cup of coffee rified Nurse Aids (CNA) #1. If CNA #1 heated the coffse resident #12 stated, "I rubbed my hand over my skin off in my hand". In skin assessment, conducted led an irregular shaped cm by 1.5 cm) red lesion on er abdomen. In a skin assessment, conducted led an irregular shaped cm by 1.5 cm) red lesion on er abdomen. In a skin assessment, conducted led an irregular shaped cm by 1.5 cm) red lesion on er abdomen. In a skin assessment at 7:10 dent #12 had requested his/her on 01/07/11 at approximately A stated she reheated the	F3	Current residents that rece request hot beverages were by the Director of Nursing 4/5/2011 to determine if a residents were affected. I included assessing cognitiand assistance level. No residents were affected. The facility staff were rethe Staff Development Counting and the supervision of resident's palatability to safety and make any need adjustments to the bevera 3/18/2011. The Director of Nursing and Development Coordinate complete a hot beverage a week for 2 weeks and weeks, and then monthly months. The Director of report the results of thes monthly to the Performs Improvement Committee includes the Medical Di Administrator, Director Market Information Market includes the Information Market information informa	re reviewed g on any other The review ion, dexterity other educated by coordinator on beverages sidents to the ensure their ded age on Assistant Staff or will audit 3 times weekly for 2 Thursing will e audits unce e, which rector, of Nursing,	

ORM CM\$-2567(02-29) Previous Versions Obsolete

Evant ID: 8J7W11

Facility ID: 100189

if continuation sheet Page 8 of 12

PRINTED: 03/30/2011 FORM APPROVED OMB NO 0938-039*

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING 8. WING O3/16/2011 STREET ADDRESS, CITY, STATE, 2IP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431 PROVIDER'S PLAN OF CORRECTION : (X5)	CENTERS FOR MEDICARE	& MEDICAID SERVICES			1	SHEVEY
INDUSTRIES AUTHUR INCLUSION VILLA CARE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCES EACH DEPICIENCY MUST IS PRECEDED BY PULL FROM EACH DOWNER OF A CONSECUTION SUMMARY STATEMENT OF DEFICIENCES EACH DEPICIENCY MUST IS PRECEDED BY PULL FROM EACH DOWNER OF A CONSECUTION CAST OF THE PRECOUNT OF THE PRECEDED BY PULL FROM EACH DOWNER OF A CONSECUTION AND CONTROL OF THE PRECOUNT OF CONSECUTION CAST OF THE PRECOUNT OF CONSECUTION AND CONTROL OF THE PRECOPNIATE CAST OF THE PRECOUNT OF THE PRECOPNIATE CAST OF THE PRECOUNT OF THE PRECOPNIATE CAST OF T	TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
F 323 Continued From page 8 check the temperature of the coffee before giving it to Resident #12. Approximately thirty minutes later CNA #1 notified the coffee on his/her abdomen. NA #1 notified the coffee on his/her abdomen. NA #1 notified the coffee on his/her abdomen. NA #1 notified the coffee on his/her instruction interviewed and had received no instruction alone the resident #12 summoned her to he resident #12 summoned her to he resident with normal saline and a gauze pad to get "sticky stuff" of the resident and monitored the resident command the resident and monitored the resident mental the next morning. LPN #1 notified the orderned notified in the resident and monitored the resident and monitored in the resident and monitored the resident a		186012				3/16/2011
SUMMARY STATEMENT OF DEFICIENCIES REACH DEFICIENCY MUST BE PERCEDED BY PULL FROM THAT PROPERTY STATEMENT OF DEFICIENCIES REQUESTORY OR ISC DENTIFY INFO INFORMATION FRETTY TAG Continued From page 8 chack the temperature of the coffee before giving it to Resident #12. Approximately thirty minutes later CNA #1 returned to the resident's room and observed what locked like a red whelp on the resident's addomen. Resident #12 told the CNA that hebsne had splited the Coffee on his/her abdomen. CNA #1 notified the Charge Nurse and was told the nurse would take care of the resident's wound. The CNA revealed she was not questioned about the incident. CNA #1 stated she was not interviewed and had received no instruction since the burn related to precautions before serving residents beverages or food that was too hot and not safe. An interview with Locensed Practical Nurse (LPN) #1, on 03/16/11 at 3.50 PM, revealed on 01/07/11 at approximately 8.30 PM, Revealed on 16/16/11 at approximately 8.30 PM, Reveale		HABILITATION CENTER		1600 PRIDE AVENUE		
check the temperature of the coffee before giving It to Resident #12. Approximately thirty minutes later CNA #1 returned to the resident's rorm and observed what looked like a red whelp on the resident's abdomen. Resident #12 told the CNA that he/she had spilled the coffee on his/her abdomen. CNA #1 notified the Charge Nurse and was told the nurse would take care of the resident's wound. The CNA revealed she was not questioned about the incident. CNA #1 stated she was not interviewed and had received no instruction since the burn related to precautions before serving residents beverages or food that was too hot and not safe. An interview with Licensed Practical Nurse (LPN) #1, on 031-011 at 3:50 PM, revealed on 01/07/11 at approximately 8:30 PM, Resident #12 summoned her to the resident's room and told her that he/she had spilled coffee on his/her atdomen. She cleaned the burn with normal saline and a gauze ped to get "sticky stuff" off the resident and monitored the resident until the next morning. LPN #1 notified the on-coming shift but did not notify the resident's physician. She stated, "just didn't call the Director of Nursing, I was trying to give medications and get things done. I didn't call the Director of Nursing, I was strying to give medications and get things done. I didn't call the Director of Nursing, I was strying to give medications and get things done. I didn't call the Director of Nursing, I was strying to give medications and get things done. I didn't call the Director of Nursing, I was strying to give medications and get things done. I didn't call the Director of Nursing, I was strying to give medications and password information to access the computer. She passed the information regarding Resident #12 to the nurse who came on duty the next morning at 7:00 AM.	(X4) ID SUMMARY PREFIX (EACH DEFICIE PREFIX PRECIDENT OF THE PROPERTY OF T	STATEMENT OF DEFICIENCIES	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETION
PM, revealed LPN #1 reported to her, in morning	F 323 Continued From particles the temperation of the Resident #12. Inter CNA #1 return observed what look resident's abdomen. CNA #1 was told the nurse resident's wound. questioned about the she was not intervise instruction since the before serving residents are to hot and not a provide the resident and monitored to give medical didn't call the physical one tied my hands, call." LPN #1 did not because she was not have the correct ideal information to access the information regardurse who came on AM.	Approximately thirty minutes and to the resident's room and sed like a red whelp on the and Resident #12 told the CNA lied the coffee on his/her notified the Charge Nurse and would take care of the The CNA revealed she was not be incident. CNA #1 stated ewed and had received no be burn related to precautions dents beverages or food that a safe. Censed Practical Nurse (LPN) 3:50 PM, revealed on 01/07/11 30 PM, Resident #12 he resident's room and told spilled coffee on his/her aned the burn with normal pad to get "sticky stuff" off the pred the resident until the next potified the on-coming shift but sident's physician. She stated, Director of Nursing, I was ations and get things done. I was new and I just didn't. No I was new and I just didn't but complete an incident report ew to the facility and did not entification and password arding Resident #12 to the duty the next morning at 7:00 PN #2, on 03/16/11 at 8:00	F3	Maintenance Director, f	or further	4/18/11

CRM CMS-2557(02-99) Previous Versions Obsolete

Eventio: 9J7W11

Facility .D: 100189

If continuation short Page 9 of 12

PRINTED: 03/30/2011 FORM: APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &	MEDICAID SERVICES	WALL	JLTIPLE CONSTRUCTION	(X3) OATE SU	
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUIL		COMPLE	TED
	186012	s. WN			6/2011
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLA CARE AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1500 PRIDE AVENUE MADISONVILLE, KY 42431	DS	
(X4) ID SUMMARY STA	(Tement of Deficiencies Must be preceded by full SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	ION SHOULD BE 'HE APPROPRIATE	DAYE
F 323 Continued From page report on 01/08/11, the coffee on his/her stom the resident's burn with a gauze on the area to clothing and bed linen wound on Resident #* pretty red. She then of her of the resident's winformation. The physicream be ordered from to the wound. LPN #2 twenty-four hour nurse pink copy in the drop to Nursing. An interview with Region/16/11 at 5:58 PM, if the twenty-four hour in been torn from the log located. RN #1 stated #12 had not been reprinted to the burn; ho expected the facility to immediately after discrete to the purn; ho expected the facility to immediately after discrete food from the color of the co	at Resident #12 had spilled tach. LPN #1 had treated h Normal Saline and placed or prevent friction with stream the LPN #2 observed the LPN #2 obs	F3	F371 No specific resident was 3/14/2011, the Dietary M and discarded the bent an goods in dry storage, the replaced under the hams according to serve safe gu mop head was discarded, up between the wall, stov freezer and the hair stuck edge drawer of the prep trand removed. The macar not served to any resident immediately removed fro by the Dietary Manager or replaced with an alternate Maintenance Director wiremove the flake and rust head and replace the floo 4/15/2011.	anager removed d dented canned drip tray was and stored widelines, the the grease build re and behind the to the corner able was cleaned roni salad was and was and the tray line on 3/14/2011 and re food. The li sand and the from the stove	

ORM CMS-2567(02-99) Previous Versions Obsciele

Event ID: 8J7W11

Facility ID: 100169

If continuation sheet Page 10 of 12

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1,,	IPLE CONSTRUCTION	(X3) DATE SURV GOMPLETED		
			A. BUILDIN				
	19	185012			03/16/	2011	
	ROVIDER OR SUPPLIER VILLA CARE AND REI	HABILITATION CENTER		RÉET ADDRESS, CITY, STATE, ZIP CO 1500 PRIDE AVENUE MADISONVILLE, KY 42431	DOE		
(X4) ID PREF'X TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENYIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 371	Continued From page	ge 10	F 371	On 3/31/11 the Dietary Meducated the cook (dieta referenced in 2567) on c touching food.	Manager re- ry staff		
	by: Based on observation determined the facilitation and serve conditions. Findings Observations of the			On 3/14/2011, a review of completed by the Dietary included the dry storage thawing food items and the food items. The kitchen of 3/14/11 by the Dietary Moleaning schedule and lothe Dietary Manager on the cresidents were affected.	y Manager that areas, process of emperature of was deep cleaned fanager. A deep g was initiated by		
	with the dry canned 2. One whole ham a ham were being that items on shelving be refrigerator. 3. A three comparism mop head laying ber rusted and flaking, it build-up between the behind the freezer. 5. Floor tiles between	cans of tuna were on a shelf goods in the dry storage. Ind one quarier of another wed on a shelf with other food aneath the hams in the walk in the sink prep area had a dirty neath the rinse sink. In the cooking stove was here was a greasy gunk and the stove and on the stove and upwards off the floor.		The Regional Dietician redictory Manager on deep deep-cleaning logs on 3/1 Dietary Manager re-educations of food under san conditions on 3/15/11. Eincluded the storing of m Federal Food Safety Guid proper serving temperature the Dietary Manager re-education clothing not touching the disposal of mop heads, has serve guidelines.	-cleaning and 5/11. The ated the staff on listribution and litary and safe ducation leats per the lelines, and res. On 3/31/11 ducated the cook in 2567) and staff food, proper		
	6. A Dietary staff wa	s leaning over the meat on their clothing was touching		To ensure the facility will distribute and serve food conditions, the Dietary M complete a Dietary Sanita	under sanitary anager will		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8J7W11

Facility ID: 100189

If continuation sheat Page 11 of 12

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391.

STATEMENT	RS FOR MEDICARE & OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185012	B. WIN			03/	16/2011
	RONDER OR SUPPLIER VILLA CARE AND REHA	BILITATION CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 800 PRIDE AVENUE MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD 8E	(X6) COMPLETION DATE
F 371	tray line was 60 degrees. 8. The drawer undern cooking utensils were of hair stuck to the cooking of the left and right. An interview with Diet 03/13/11 at 11:15 AM deep cleaning schedulthe last time deep clear completed was in Feb unsure as to why a direct the prep sink. An interview with the I	e macaroni salad on the ses on 03/13/11 at 4:55 PM. eath the prep table where stored, had a large clump mer edge of the drawer on sides. ary Manager (DM), on revealed there were no le logs kept. She thought aning of the kitchen was ruary 2011. She was ty mop head was left under DM, on 03/13/11 at 5:25 aroni Salad temperature	F	371	audit 3 times a week for 2 weeks weekly for 2 weeks and monthly The Dietary Manager will report the Performance Improvement Committee. The Administrator of complete a Dietary Sanitation In audit twice weekly for 2 weeks, for 2 weeks and monthly times 2 Administrator will report results audits to the Performance Improvement Committee, which includes the Noirector, Administrator, Director, Nursing, Health Information Ma Maintenance Director for further recommendations. Completion date	rtimes 2. results to will dicator weekly . The of the vement Medical r of mager and	04/18//11

FORM CMS-2587(02-89) Previous Versions Obsolete

Event ID: 8J7W11

Facility ID: 100189

If continuation sheat Page 12 of 12

PRIMARY: 03/30/2011 FORM ARPROVED OMB NO 9938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CURRECTION A BUILDING 01 - MAIN BUILDING (ii) B. WNG 03/15/2011 / 185012 STREET ACORESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1800 PRIDE AVENUE HILLSIDE VILLA CARE AND REHABILITATION CENTER MADISONVILLE, KY 42431 PROMDER'S PLAN OF CORRECTION (X6) SUMMARY STATEMENT OF DEFICIENCIES EACH CORRECTIVE ACTION SHOULD SEO CO (X4) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY K 000 K 000 INITIAL COMMENTS The plan of correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor A Life Safety Code Survey was conducted on content is to be construed as an admission 03/15/11 to determine Federal compliance with by the provider of the validity of any Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in findings or citations contained herein. compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest scope and severity of an "E". K 025 NFPA 101 LIFE SAFETY CODE STANDARD K 025 K025 SS=E Smoke barriers are constructed to provide at No specific resident was identified. The least a one half hour fire resistance rating in space surrounding the cables on the 200 accordance with 8.3. Smoke barriers may hall medicine storage room behind the terminate at an atrium wall. Windows are nurse's station was filled with a material protected by fire-rated glazing or by wired glass which would resist the passage of smoke panels and steel frames. A minimum of two on 3/18/2011 by Maintenance Director. separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. An audit was completed in the building by Maintenance Director on 03/21/11 to 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 determine if there were any openings in smoke partitions that would not resist the passage of smoke. Identified areas corrected at that time. No residents were This STANDARD is not met as evidenced by: affected. Based on observations and staff interviews conducted on 03/15/11, it was determined the facility falled to maintain smoke barriers that would resist the passage of smoke between smoke compartments. This condition affected two The Maintenance Director was re-(2) smoke compartments, including educated on the NFPA 101 Life Safety approximately 90 residents and also staff and Code regarding smoke barriers that would visitors. Findings include: resist the passage of smoke between smoke compartments by the A tour of the facility conducted on 03/15/11, Administrator on 3/21/2011 revealed the cailing on the 200 hall medicine storage room behind the nurse's station was noted with approximately 10 communication

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sufequends provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above rindings and plane of correction are disclosable 14 days following the date these decuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-58) Previous Versions Obsolete

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Event 10: 817WE1

Feeliny 10: 100189

If continuation sheet Page 1 of 2

YITLE

CENTERS FOR MEDICARE & MEDICAID SERVICES はばい ひんまた ちじドマぞう (X1, PROVIDER/SUPPLIER/CUA (X9) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETER AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 185012 03/15/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1800 PRIDE AVENUE HILLSIDE VILLA CARE AND REHABILITATION CENTER MADISONVILLE, KY 42431 (XĎ) COMPLETION DATS FROVIDER'S PLAN OF CORRECTION RUMMARY RYATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUSY BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION: TAG TA6 DEFICIENCY) K 025 K 025 Continued From page 1 cables through a 1-1/2 inch hole. The space The Maintenance Director or surrounding the cables was not filled with a Housekeeping Supervisor will complete a material which would resist the passage of facility smoke partition audit once a week smoke. for 4 weeks and once a month for 2 months. The Maintenance Director will An interview with the Maintenance Director, on report results to the Performance 103/15/11 at 11:15 AM, revealed he was aware of Improvement Committee,, which includes the fire code requirement but had overlooked the the Medical Director, Administrator, lack of sealant around the condult in this Director of Nursing, Health Information particular room. Manager and Maintenance Director for further recommendations. Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2,4,4 Penetrations and Miscellaneous Openings In Smoke Partitions. Pipes, conduits, bus ducte, cables, wires, air Completion date 4/18/11 ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows. The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.

PRIMARY: 03/30/2011 FORM ARPROVED OMB NO 9938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CURRECTION A BUILDING 01 - MAIN BUILDING (ii) B. WNG 03/15/2011 / 185012 STREET ACORESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1800 PRIDE AVENUE HILLSIDE VILLA CARE AND REHABILITATION CENTER MADISONVILLE, KY 42431 PROMDER'S PLAN OF CORRECTION (X6) SUMMARY STATEMENT OF DEFICIENCIES EACH CORRECTIVE ACTION SHOULD SEO CO (X4) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY K 000 K 000 INITIAL COMMENTS The plan of correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor A Life Safety Code Survey was conducted on content is to be construed as an admission 03/15/11 to determine Federal compliance with by the provider of the validity of any Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in findings or citations contained herein. compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest scope and severity of an "E". K 025 NFPA 101 LIFE SAFETY CODE STANDARD K 025 K025 SS=E Smoke barriers are constructed to provide at No specific resident was identified. The least a one half hour fire resistance rating in space surrounding the cables on the 200 accordance with 8.3. Smoke barriers may hall medicine storage room behind the terminate at an atrium wall. Windows are nurse's station was filled with a material protected by fire-rated glazing or by wired glass which would resist the passage of smoke panels and steel frames. A minimum of two on 3/18/2011 by Maintenance Director. separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. An audit was completed in the building by Maintenance Director on 03/21/11 to 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 determine if there were any openings in smoke partitions that would not resist the passage of smoke. Identified areas corrected at that time. No residents were This STANDARD is not met as evidenced by: affected. Based on observations and staff interviews conducted on 03/15/11, it was determined the facility falled to maintain smoke barriers that would resist the passage of smoke between smoke compartments. This condition affected two The Maintenance Director was re-(2) smoke compartments, including educated on the NFPA 101 Life Safety approximately 90 residents and also staff and Code regarding smoke barriers that would visitors. Findings include: resist the passage of smoke between smoke compartments by the A tour of the facility conducted on 03/15/11, Administrator on 3/21/2011 revealed the cailing on the 200 hall medicine storage room behind the nurse's station was noted with approximately 10 communication

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sufequends provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above rindings and plane of correction are disclosable 14 days following the date these decuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-58) Previous Versions Obsolete

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Event 10: 817WE1

Feeliny 10: 100189

If continuation sheet Page 1 of 2

YITLE

CENTERS FOR MEDICARE & MEDICAID SERVICES はばい ひんまた ちじドマぞう (X1, PROVIDER/SUPPLIER/CUA (X9) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETER AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 185012 03/15/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1800 PRIDE AVENUE HILLSIDE VILLA CARE AND REHABILITATION CENTER MADISONVILLE, KY 42431 (XĎ) COMPLETION DATS FROVIDER'S PLAN OF CORRECTION RUMMARY RYATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUSY BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION: TAG TA6 DEFICIENCY) K 025 K 025 Continued From page 1 cables through a 1-1/2 inch hole. The space The Maintenance Director or surrounding the cables was not filled with a Housekeeping Supervisor will complete a material which would resist the passage of facility smoke partition audit once a week smoke. for 4 weeks and once a month for 2 months. The Maintenance Director will An interview with the Maintenance Director, on report results to the Performance 103/15/11 at 11:15 AM, revealed he was aware of Improvement Committee,, which includes the fire code requirement but had overlooked the the Medical Director, Administrator, lack of sealant around the condult in this Director of Nursing, Health Information particular room. Manager and Maintenance Director for further recommendations. Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2,4,4 Penetrations and Miscellaneous Openings In Smoke Partitions. Pipes, conduits, bus ducte, cables, wires, air Completion date 4/18/11 ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows. The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.